HONORABLE MENTION

GENDER REASSIGNMENT SURGERY AND THE GYNECOLOGICAL PATIENT

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With the increasing number of open transsexuals in the population and the advances in reconstructive surgical techniques, gender reassignment surgery has been increasing since the 1960s. Secondary to the increase in patients undergoing gender reassignment surgery, the practicing gynecologist is more likely to encounter a transsexual patient. A 49-year-old, nulligravid, white female presented to the gynecology clinic for her annual gynecological exam. Her past surgical history was significant for male to female gender reassignment surgery in 1991. Her hormonal medications included levothyroxine and estrogen. She described a strong family history of breast cancer for which she was being followed in our institutional Breast Watch Clinic. On physical examination, findings were notable for surgically constructed female external genitalia and a neovagina. The rectal exam was normal and failed to demonstrate any prostate pathology. It is important for the experienced gynecologist to be familiar with transsexualism, the reconstructive surgery involved, the surgical complications, and gender identity support groups and clinics available to these patients. Transsexuals should be treated to the extent possible like other female gynecological patients, while care is taken not to overlook underlying or preexisting medical conditions, including conditions unique to the prior and new genders. (Prim Care Update Ob/Gyns 2001;8:22–24.

Transsexualism, also known as gender dysphoria, is the most complete and profound disorder of gender identity. Gender identity is one's inner sense or basic awareness to which sex one belongs. "I am male" or "I am female." Gender role is the public expression of one's gender identity. Behaviorally, transsexualism manifests as an individual living in the role of the gender opposite to his or her physical anatomy.[1] Transsexualism was first described in the 1950s by Benjamin and is now widely recognized. Transsexualism is now considered a true disease, rather than a variation from the norm.[2]

Case

A 49-year-old, nulligravid Caucasian female (status after transgender surgery, male to female, in 1991) presented to the ob/gyn clinic for her annual gynecological examination and Papanicolaou smear. The patient presented without any specific complaints. She was in a stable sexual relationship with a male partner. Because of a strong family history of breast cancer and her concurrent use of estrogen therapy, she was also being followed in the institutional Breast Watch Clinic. Additional medical problems included obesity, type II diabetes mellitus, hypothyroidism, bipolar disorder, and posttraumatic stress disorder. She was receiving routine medical care in the internal medicine and psychiatric departments for the above medical conditions, which were well controlled on medical therapy. The patient's body mass index was 49, consistent with morbid obesity. The thyroid was palpable but without masses or thyromegaly. She had not undergone breast augmentation, and the breast examination revealed symmetrical breasts without masses or galactorrhea. The abdomen was obese, soft, and without palpable masses. The gynecological portion of the examination revealed surgically constructed female genitalia to include a clitoral hood and labia. The urethral meatus was inferior to the clitoral hood and superior to a neovagina. The neovagina ended in a blind pouch and was similar in appearance to a posthysterectomy atrophic vagina. As expected, the cervix, uterus and ovaries were congenitally absent. The rectal exam revealed a smooth prostate without palpable masses, and the stool was guiac negative. The patient was counseled extensively regarding the use of estrogen with her family history of breast cancer, and she decided to continue hormonal therapy. She was also counseled on monthly breast self-exams and

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The opinions and assertions contained herein are the private views of the authors and are not constructed as official or as reflecting the view of the Department of the Army or the Department of Defense.

  1068-607X/01/$20.00 • PII S1068-607X(00)00065-2

about sexually transmitted diseases, and she was encouraged to lose weight. The patient was given a refill of premarin and instructed to return to the clinic in 1 year or as needed. The cytologic smear of the neovagina returned with features consistent with bacterial vaginosis, but otherwise there was no dysplasia or atypia. The mammogram revealed no radiographic evidence of malignancy.

Incidence

The number of transsexual patients seeking either vaginoplasty or phalloplasty increased dramatically in the 1980s.[3] A conservative estimate of the number of people suffering from gender dysphoria is approximately 30,000 worldwide. In the United States, at least 10,000 are known to have some form of gender-identity disorder.[4]

The cause for an increase in the awareness and acceptance of transsexualism is unknown but may be due to the increase in sexual openness and education that is provided in some part by the media.[5] Furthermore, in the entertainment world, cross-gender behavior is openly portrayed and positively reinforced.[6] Why the dramatic increase in the requests for surgery? Advances in plastic surgery and increased availability of surgeons and clinics specializing in genital reconstruction may have contributed to the increase in the number of patients seeking surgical reassignment.

From the 1960s to the 1970s, the ratio of male to female transsexuals requesting surgery reassignment was 4.5:1. However, during the 1980s, the ratio has approached 1:1. The patients requesting these procedures are younger than those of a decade ago, and very often, they have the support of their friends and families. With the evolution of new and improved surgical techniques for genital reconstruction, more transsexuals are electing surgical sexual reassignment.[6]

Patient Selection

A careful and extensive evaluation must be completed in order to ensure proper patient selection for gender reassignment surgery. Almost all transsexuals are psychologically complex individuals.[6] They often have underlying psychiatric disorders. Indeed, our patient suffered from bipolar disorder and posttraumatic stress disorder. It wasn't until the 1980s, when the American Psychiatric Association published the *Diagnostic and Statistical Manual of Mental Disorders*, 3rd edition (DSM-III), that standard descriptive criteria for the psychiatric diagnosis and treatment of transsexualism were released. The criteria include individuals that have reached puberty and have the persistent discomfort and sense of inappropriateness about their assigned sex. These persons have the persistent preoccupation for at least 2 years with getting rid of their primary or secondary sex characteristics and acquiring the sex characteristics of the other sex.[7] The responsible approach to the diagnosis and treatment of these complex patients is multidisciplinary. To help care for these complex patients, several gender identity clinics have been developed to incorporate this team approach, to include the urologist, gynecologist, plastic surgeon, and psychiatrist.[6]

Transsexualism and the Gynecologic Patient

As the awareness of transsexualism increases, so will the number of patients undergoing transgender surgery. As part of their new gender, they will be presenting to their primary care provider for their annual health maintenance examination and pelvic exam. It is important for the experienced gynecologist to evaluate and treat these patients (as much as possible) like other female gynecological patients. As part of their physical examination, a breast and pelvic examination should be included and routine screening tests obtained (eg, Papanicolaou smear, mammogram, screening for sexually transmitted diseases). It is also necessary not to overlook underlying or preexisting medical conditions (eg, mental health conditions, hypertension, obesity, diabetes) or risks that may be incurred due to hormone manipulation (eg, breast cancer). It is also important to evaluate for disease processes unique to their prior gender, such as prostate cancer or breast cancer. Surprisingly, in this patient, the cytologic smear returned with features consistent with bacterial vaginosis. These patients may present for evaluation of certain gynecologic conditions and infections (eg, dysplasia, vaginitis), and the gynecologist should be ready to offer the appropriate therapy. The gynecologist should have a general knowledge of the reconstructive surgical procedures and of the potential postoperative complications in order to assist the plastic or urologic surgeons in the event of consultation.

Gender Identity Clinics

The development of gender identity clinics and support groups has made a great impact on the emotional support of these patients and their families. These patients need assistance in helping to redefine their roles as parents, coworkers, friends, and lovers. The groups are designed to help the patient and their families to become more accepting of the new gender. These groups also provide support and guidance to patients who are having

difficulties in dealing with their loss of fertility. An important part in the multidisciplinary approach to caring for transsexuals includes referral of the patient and their family members for participation in these groups.

Conclusion

As the number of transsexuals undergoing transgender surgery increases, it is important that the experienced gynecologist be familiar with transsexualism, the reconstructive surgery involved, the surgical complications, and the transgender support groups available. As part of their new gender, they will be presenting for their annual gynecological examination. Transsexuals should be treated, to the extent possible, like other female gynecological patients, while care is taken not to overlook underlying or preexisting medical conditions, including conditions unique to their prior gender. A team approach including the urologist, gynecologist, plastic surgeon, and psychiatrist should be used in treating these complex patients.

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